Medical School Hotline

Controversies in Medical Education
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What is controversial in medical education is changing as rapidly as changes in health care delivery systems. Until recently, debates centered around issues such as problem-based learning, methods of ambulatory care training, centralized decision making and resource allocation for medical students' education programs, and training faculty to be effective teachers. Then, issues regarding community involvement in program development joined the discussion in recognizing the patient and the community as the ultimate customer of medical education. Closely related to this has been the recognition that an understanding of the social sciences, as well as the biologic sciences, is needed to address the social causes and correlates of illness in caring for patients and their communities.

Most recently, attempts to cut costs of medical care through decreased third-party reimbursements, through reductions in hospital reimbursements for graduate medical education, and through managed care have made the financing of medical education the most controversial issue. Controversies regarding the means of financing medical education have eclipsed the more academic issues.

The issue now for many medical schools is survival. Large academic health centers rely on revenues from specialty care referrals to fund education in their parent medical school. They have neglected the market shift to managed care with emphasis on primary care, and their referrals and income have dropped markedly.

Late in the game, medical schools have adopted various strategies to regain their patient base. Some have formed their own PHO or HMO with primary care networks feeding their specialists and hospitals. In this arrangement, the role of department chairs is changing to that of a more collaborative team player with practicing, revenue-producing faculty having greater participation in decision making. The role of deans is changing to that of CEO of the entire clinical enterprise. Some schools have partnered with HMOs to effect the same result. Some HMOs are attempting to buy medical schools or partner with medical schools to provide a continuous supply of primary care physicians for their expanding operations. They look to train them to fit their particular value systems and cultures, and to train them to work efficiently in managed care settings.

These survival tactics raise concerns about the driving forces of medical care and education. Currently the main force nationally is economic survival and not quality care. Employers are understandably clamoring for relief from the escalating costs they must pay for their employees' medical care, while methodologies for assessing quality are still in the development stage. Only when costs are lower and quality can be measured convincingly will quality become the driving force.

Controversies abound about the impact of financial exigencies on medical education. Will medical curricula be determined by the bottom line of the clinical enterprise, by the goals of the academic enterprise, by the desires of faculty, or by the needs of patients or communities? Where is research in all of this and how will it be funded?

Medical education is best done in an excellent health care system that provides appropriate, acceptable, accessible, and effective care at the lowest possible cost. Students model their behavior after that of the practitioners in the system to become excellent physicians.

As our care systems change at an increasing rate, medical schools will need to either respond to the ever- changing models or lead the change by developing new models of their own. In either instance, increasing competition for patients will drive physicians to effectively organize into powerful, profitable groups to be able to win contracts for large numbers of patients. An evolving model is one similar to Andersen Consulting in which physicians and perhaps other health care providers are members of large, national professional corporations contracting for services in every state in the U.S. These corporations have their own universities to supply newly trained members for the corporation and to continually train all corporate members to benefit the corporation.[1] The extent to which these models deliver high-quality care will determine the quality of medical education. If high-quality medical education is to survive, educators must be actively involved in designing and operating these systems.

References

1. *To the Greater Good: Recovering the American Physician Enterprise.* The Governance Committee, Advisory Board Company, 1995.